Lewisham
Safeguarding Adults Board
A working partnership to prevent abuse

Safeguarding Adults Review
Eileen Dean

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Independent Reviewer
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Contents

SAFEGUARDING ADULTS REVIEW – Eileen Dean

1. INTRODUCTION

1.1 Eileen Dean was a 93-year-old white British woman who had moved into a care home in Lewisham in June 2020. At 12.30am on 4 January 2021, she was assaulted whilst lying in bed by another adult (to be referred to in this report as 'The Adult'), a fellow resident. Eileen sustained significant injuries and died in hospital later that day.

1.2 The Adult is a white British man who was 62 years old when he physically assaulted Eileen. He had been admitted to a general medical ward at the University Hospital Lewisham (UHL), a hospital operated by Lewisham and Greenwich NHS Trust (LGT) on 11 July 2020 following alcohol withdrawal seizures.

1.3 The Adult was sectioned under Section 2 of the Mental Health Act 1983 (MHA) and transferred to Powell Ward at the Ladywell Unit, an inpatient psychiatric unit at UHL, operated by South London and Maudsley NHS Foundation Trust (SLaM) where he contracted Covid-19. The Adult was then transferred to Florence Ward, a dedicated Covid-19 ward at Lambeth Hospital, for mental health patients. Lambeth Hospital is also operated by SLaM.

1.4 The Adult recovered from Covid-19 and was then transferred to Luther King Ward (Lambeth Hospital), from where he was placed into the 'care home' in Lewisham on Section 17 Mental Health Act 1983/2007 (MHA) leave on 22 December 2020.

1.5 The Adult is currently detained in a secure psychiatric ward on an Indefinite Hospital Order under Section 48/49 of the MHA.

1.6 Although this Safeguarding Adults Review (SAR) is about the events leading to Eileen Dean's death, its main focus is on The Adult and how he came to live in the same part of a residential care home with her.

1.7 **Family Involvement**

1.8 The report writer and the Lewisham Safeguarding Adults Board (LSAB) Business Manager met with Eileen's daughter and son-in-law to find out more about Eileen. Permission was not sought or obtained from The Adult to contact his mother, but information obtained from his mother prior to the start of the SAR by a social worker, and by the care home, is included in the report.

1.9 **The Reviewer**

1.10 Patrick Hopkinson is an experienced adult social services and health services consultant with previous experience of Safeguarding Adults Reviews and Domestic Homicide Reviews.

2. SAFEGUARDING ADULTS REVIEWS

2.1 Section 44 of the Care Act 2014 places a statutory requirement on the Lewisham Safeguarding Adults Board to commission and learn from Safeguarding Adults Reviews (SARs) in specific circumstances, as laid out below, and confers on Lewisham Safeguarding Adults Board the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

Arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –

a) identifying the lessons to be learnt from the adult's case, and
b) applying those lessons to future cases.

Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (Section 44 (5), Care Act 2014).

2.2 The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Adult Safeguarding Policy & Procedures - April 2019 and can be summarised as follows:

2.3 SABs must arrange a SAR when an adult in its area with care and support needs dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult with care and support needs, in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

2.4 SABs may arrange for a SAR in any other situations involving an adult in its area with care and support needs, whether or not they are being met by the Local Authority. The SAB may also commission a SAR in other circumstances

where it feels it would be useful, including learning from ‘near misses’ and situations where the arrangements worked especially well. The SAB decides when a SAR is necessary, arranges for its conduct and if it so decides, implements the findings.

2.5 The criteria are met when:

2.6 An adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death; or

2.7 An adult has sustained a potentially life threatening injury through abuse, neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect; and one of the following:

2.8 – Where procedures may have failed and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk;

2.9 – Serious or apparently systematic abuse that takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale and may require more time;

2.10 – Where circumstances give rise to serious public concern or adverse media interest in relation to an adult/adults at risk.

2.11 There is an expectation that individuals, agencies, organisations, cooperate with the review but the Act also gives Boards the power to require information from relevant parties. The SAB may also commission a SAR in other circumstances where it feels it would be useful, including learning from ‘near misses’ and situations where the arrangements worked especially well. The SAB should decide when a SAR is necessary, arrange for its conduct and if it so decides, implement the findings.

2.12 All LSAB members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice (“tell it like it is”).

2.13 This case was referred to the LSAB in March 2021 for their consideration of a Safeguarding Adults Review by the London Borough of Lewisham – Adult Social Care – Safeguarding and Quality Assurance Team.

2.14 The LSAB delegates these decisions to a Case Review Sub-Group who assessed the case on the 4 March 2021, where it was decided that the ‘mandatory’ criteria for a Safeguarding Adults Review, as set out in Section 44 of the Care Act 2014 had been met, and that this review would examine the relevant history of both adults identified in this case. The review was delayed due to ongoing criminal justice processes, and The Adult was sentenced on 20 December 2021, following which the review commenced in February 2022.

3. BRIEF SUMMARY OF CHRONLOGY AND CONCERNS

3.1 Eileen Dean's Background

3.2 Eileen Dean was born in Bermondsey and was one of eight children, and despite being intelligent and academically capable, she left school at 14 years of age and worked in several factories where she progressed to work as an administrator.

3.3 Eileen loved dancing and through this met her husband. They had a happy marriage, three children and five grandchildren, but Eileen was widowed in her early 60's. Eileen was a devout Roman Catholic and regularly attended church. She enjoyed Bingo and horse racing, developed a love of the theatre, and was always a happy, cheerful and gentle lady who had time for everyone.

3.4 Eileen led a full and independent life until she developed dementia, which ultimately curtailed her interests, and finally her ability to attend church. Although her capabilities were reduced by dementia, Eileen remained happy and contented.

3.5 Eileen moved to the care home in June 2020 and contracted Covid-19 after Christmas 2020. Although Eileen did not show any symptoms, she isolated in her room. Staff at the care home described how Eileen had lovely clothes and personal items brought by her daughter and was very comfortable. Due to Covid 19 restrictions, visits to the care home were not permitted or were only brief. Eileen was in regular contact with her daughter by telephone. Eileen did not mention The Adult during these conversations but this should not be taken to mean that she had no concerns. Eileen was hard of hearing and telephone calls were described by her daughter as very difficult.

3.6 The care home described Eileen's family as very supportive and commented that Eileen's room was immaculate and that Eileen took great pride in her appearance.

3.7 The Adult's Background

3.8 The Adult, according to South London and Maudsley NHS Foundation Trust (SLaM), had struggled with alcohol use throughout much of his adult life; he had started drinking when he was 15 years old and by 19 years old, whilst at university, this usage had become problematic. Despite this The Adult is said to have graduated in mechanical engineering. According to The Adult, he then worked in engineering and computer programming. The Adult had three children, whom he said he was not in contact with. The Adult's mother lived in Lincolnshire.

3.9 The Adult was understood by SLaM to have been exposed to multiple traumatic events from childhood onwards. These included separation from family members, the breakdown of relationships, and witnessing the death of others. The Adult's family were transient during his childhood due to his father's work, and while living as a family in Nigeria, The Adult witnessed deaths in the 1967-1970 civil war. The Adult's family were evacuated, and The Adult was sent to boarding school after which time he saw his parents once a year. In 1984 The

Adult's then girlfriend killed herself. The Adult had a motorbike accident in 1995, resulting in a knee injury and prolonged pain, for which he may have used cannabis to self-medicate. In 2001 The Adult said that several hundred of his colleagues died in the Twin Towers terrorist attack.

3.10 The Adult's mental health is recorded as deteriorating in 2002. At the time he was using cannabis heavily alongside alcohol and was sectioned for three weeks under the MHA in a hospital in Lincolnshire. The Adult said that a diagnosis of bipolar disorder had been made and that he had been stabilised on anti-depressant medication. After Eileen Dean's death, it was found that The Adult had contact with the criminal justice system and had spent a short time in prison. He also had short periods of contact with mental health services.

3.11 The Adult first came to the attention of SLaM in January 2014 following referral by his GP for alcohol dependency. The Adult was reported to be motivated to reduce his alcohol intake, particularly to remedy relationship difficulties with his current girlfriend. The Adult was working in a supermarket and living in a bedsit.

3.12 SLaM had some contact with The Adult in 2014-2015 but engagement was described by SLaM as inconsistent. However, following inpatient detoxification in December 2014, The Adult was able to achieve abstinence from alcohol. He was discharged to the care of his GP and SLaM had no further contact with The Adult until he was admitted to UHL on 11 July 2020 following an alcohol withdrawal related seizure.

3.13 By this time The Adult had been dismissed from his job when cannabis was found in his locker at work, and it was hypothesised by a SLaM psychiatrist on 24 December 2020 that this dismissal may have led to an escalation in The Adult's depression and alcohol use. A brain scan identified that The Adult had Encephalopathy (a disease of the brain, resulting in an altered mental state) due to Wernicke-Korsakoff's Syndrome. This may also mean, as described later in this report, that The Adult's account of his background may not have been entirely accurate.

3.14 **Events from July 2020 to January 2021**

3.15 On 11 July 2020, The Adult was admitted to UHL with alcohol withdrawal seizures.

3.16 Between 5 August 2020 and 4 September 2020, there were at least 34 recorded incidents of The Adult's violence or threats to patients or staff, with multiple incidents during some of these violent outbursts. These incidents occurred on a general medical ward at UHL (provided by Lewisham and Greenwich NHS Trust). In response The Adult received support from a Registered Mental Nurse (RMN) who remained with him through the day and night, and hospital security were called a number of times to deal with these incidents.

3.17 The incidents included The Adult threatening to use a bread knife, scissors and dinner trays as weapons; making threats and expressing paranoid thoughts about staff and patients, including a threat to kill the RMN; throwing items, often jugs of water or cups at staff or patients, and smashing equipment ranging from

ward computers to a radio and a crash trolley. The Adult was also agitated, angry, abusive or aggressive towards patients and staff.

3.18 On 12 August 2020, during the time of these incidents, the process to discharge procedure began, and by 26 August 2020 it was noted to be becoming clear that The Adult would not be able to return home *"due to current cognition and risk to self and others".*

3.19 On 3 September 2020 in response to these risks, The Adult was detained under Section 2 of the MHA. He remained on the general medical ward waiting for a bed at the Ladywell Unit (the inpatient mental health facility at UHL provided by SLaM).

3.20 On 15 September 2020 The Adult was admitted to Powell Ward (Ladywell Unit) and his GP was notified by UHL that The Adult's discharge destination would be *"High Security Psychiatric".* No definition was provided of what *"High Security Psychiatric"* meant and a general acute psychiatric ward rather than a Psychiatric Intensive Care Unit (PICU) was requested.

3.21 On 17 September 2020, Powell Ward referred The Adult to Lewisham Social Services to assist in identifying accommodation for him. Lewisham Social Services contacted The Adult's family for additional information about The Adult to inform the Care Act Assessment process. On 22 September, Powell Ward noted that The Adult would require dementia friendly accommodation, likely under Deprivation of Liberty Safeguards**.**

3.22 On 1 October 2020, a social worker attended a ward round meeting where the need for 24-hour supported accommodation due to The Adult's cognitive impairment was discussed.

3.23 On 14 November 2020, Powell Ward staff recorded a note to treat The Adult as a dementia patient. On 13 November 2020, Lewisham Social Services referred The Adult to the Continuing Health Care Team which concluded on 16 November 2020 that The Adult did not meet the threshold for Continuing Health Care funded nursing care.

3.24 On 17 November 2020, a social worker requested permission from Lewisham Council's funding panel to secure a placement for The Adult in a residential unit which worked with people with dementia. On 26 November 2020, The Adult was referred to, and assessed by the care home. This was not a High Security Psychiatric placement and LGT's discharge note to The Adult's GP does not appear to have influenced decisions about where The Adult should be discharged, nor was it shared with the care home.

3.25 On 2 December 2020 The Adult contracted Covid-19 on the Ladywell Unit and became unwell. He was transferred on 4 December 2020 to Florence Ward, at Lambeth Hospital.

3.26 By 17 December 2020 The Adult had recovered from Covid-19 and was admitted to Luther King Ward, still at Lambeth Hospital, since no bed was available for him to return to Powell Ward at the Ladywell Unit. On 18

December 2020 The Adult tested positive for Covid-19 again but did not show any symptoms.

3.27 On 22 December 2020 a meeting was held online by Microsoft TEAMS between the care home and Luther King Ward. The Adult was then placed at the care home on Section 17 (MHA) leave.

3.28 Between 23 December and 26 December 2020 The Adult received one-to-one day time support to help him settle into the care home. On 30 December 2020 a risk assessment was completed to allow The Adult to use a laptop computer.

3.29 **Events on the Night of 3 and 4 January 2021**

3.30 On the evening of 3 January 2021 The Adult returned the laptop to the office at the care home. At 12.35am on 4 January 2021 night staff noticed on CCTV that The Adult was walking around the hall on the second floor near Eileen Dean's room, and using his mobile telephone. A member of the night staff went to investigate and found that The Adult was speaking to the police. The Adult then said, *"she is dead"* and pointed to Eileen's room. The member of staff entered Eileen's room and then told the police to come quickly because Eileen was severely injured.

3.31 It appears that The Adult had entered Eileen's room and had beaten her with a crutch. Eileen was taken to hospital but died later the same day.

4. THE EVIDENCE BASE FOR THE REVIEW

4.1 Preston-Shoot (2019) argues that: "*Drawing on existing evidence about effective practice would mean that reviewers are not starting out with a blank canvas. What is proposed here is that SARs begin explicitly with the available evidence-base, using it as a lens with which to scrutinise case chronology and explore through panel meetings, interviews and learning events with practitioners and managers what facilitates good practice and what presents barriers to effective practice."*

4.2 The advantage of this approach is that: *"The emphasis then is less on description and more on immediate reflection and systemic analysis of facilitators and barriers, across nationally determined policy, legal and financial systems as well as local arrangements and staff values, knowledge and skills*" (Preston-Shoot, 2019).

4.3 Consequently, a study was made of both the research evidence and practice evidence.

4.4 **Adverse Childhood Experiences and the Impact of Trauma**

4.5 It appears that The Adult may have experienced and witnessed traumatic events throughout his childhood and continued to experience them into adulthood.

4.6 There are strong evidential, as well as logical and intuitive links between trauma in childhood, and the experience in adulthood of mental ill health,

excessive use of drugs and/ or alcohol, self-neglect, chaotic and abusive personal relationships (Lewis et al, 2021; Maniglio, 2019; Greenfield, 2010). Traumatic events in childhood are often referred to, somewhat euphemistically since the term barely captures their extremely disturbing nature, as Adverse Childhood Experiences (ACE) (Felitti et al, 1998).

4.7 ACEs include growing up in a household with someone who has mental health needs, misuses substances, or has been involved in the criminal justice system. They include exposure to child maltreatment or domestic violence, witnessing traumatic events and also losing a parent through divorce, separation or death (WHO, 2012). People who have experienced traumatic events can feel more easily threatened or *"triggered"* in a range of settings including ones where no obvious threat is present (Donohoe, 2022).

4.8 The impact of ACEs appears to be cumulative, with risks of poor outcomes increasing with the number of ACEs suffered. There is also considerable practice and research evidence that people with a history of trauma struggle to engage with the services that try to help and support them. The Adult's contact with mental health services prior to the events in this SAR, for example, was typified by difficulties faced by mental health services in engaging with him.

4.9 The impact of exposure to ACEs should not, however, be considered too deterministically. Many people who have faced ACEs become well-adjusted and successful adults. Understanding the impact of ACEs can, however, help in formulating responses and interventions to support people who have experienced them.

4.10 The significance of history taking will be considered in this report.

4.11 **Evidence for Wernicke-Korsakoff's Syndrome**

4.12 The Adult had, and was treated for, Wernicke's Encephalopathy. Wernicke's Encephalopathy is the result of insufficient levels of vitamin B1, otherwise known as Thiamine. Vitamin B1 is essential for brain function, and unless treated with additional vitamin B1, Wernicke's Encephalopathy is likely to develop into Korsakoff's Syndrome. Vitamin B1 deficiency leading to Wernicke's Encephalopathy can have numerous causes but Korsakoff's Syndrome is most closely related to excessive consumption of alcohol. As a result, The Adult was treated with vitamin B1.

4.13 Symptoms of Wernicke-Korsakoff's can be similar to those of dementia, although the causes are different and recovery from Wernicke-Korsakoff's Syndrome is sometimes possible depending on how quickly the condition is treated and if abstinence from alcohol can be achieved.

4.14 Wernicke-Korsakoff Syndrome occurs in up to 2% of people worldwide and approximately 50% of those who develop Wernicke Encephalopathy eventually develop Korsakoff Syndrome. The number is higher (80%) among those who have alcohol use disorder.

4.15 It is likely that Wernicke-Korsakoff Syndrome will be more familiar to addiction services than to general psychiatry, but its presentation is not unknown.

4.16 The Adult was thought to have had no history of cognitive impairment. The clinical suspicion was that he had acquired Wernicke's Encephalopathy which had progressed to Korsakoff's Syndrome and a brain scan confirmed that he had a brain injury as a result.

4.17 Wernicke-Korsakoff Syndrome is a two-stage process. Wernicke's Encephalopathy is a first and short-lasting phase and Korsakoff Syndrome or Korsakoff 'psychosis' is the long-lasting stage.

4.18 The most common symptoms of Wernicke's Encephalopathy are confusion; inability to coordinate voluntary movements and visual problems.

4.19 The most common symptoms associated with Korsakoff's Syndrome are:

4.20 Amnesia or inability to form new memories.
4.21 Behavioural changes, such as agitation or anger.
4.22 Confabulation.
4.23 Delirium and disorientation.
4.24 Fatigue or lethargy.
4.25 Hallucinations, especially in those withdrawing from alcohol.
4.26 Lack of focus, or attention.
4.27 Unsteady gait.

4.28 Of these, the most commonly associated symptom is memory loss and the inability to form new memories. In order to make up for memory loss, people with Korsakoff's Syndrome archetypally construct or *"confabulate"* false memories. These are often expressed forcefully and believably and are resistant to challenge. There is evidence that The Adult's own accounts of his history may not always have been accurate. For example, on 15 September 2020, The Adult said that he had *"fancy ideas"* about being a computer programmer and a car designer but that he realised that this was not possible because he was *"mentally ill".* The Adult also claimed to have been in the Army when at the Ladywell Unit, but this was unlikely. The accounts given in this report of The Adult's background, therefore, should also be considered within this context.

4.29 Whilst there is well developed provision for older adults with dementia, this is not the case for adults with young on-set or acquired dementia, who present with less homogeneous needs and risk, and for whom more services are required (Stamou et al, 2021).

4.30 Korsakoff's Syndrome is a form of executive functioning deficit, which can impact on a person's mental capacity.

4.31 **Mental Capacity and Wernicke-Korsakoff's Syndrome**

4.32 The Adult was judged not to have the mental capacity to make decisions about his care, welfare and treatment. The Mental Capacity Act (MCA) 2005 sets out the legal framework for understanding, assessing and intervening in, the ability of people with an impairment in the functioning of their mind or brain to make decisions.

4.33 The MCA does not yet (although subject to consultation and revision) explicitly recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action). This is, however, an important distinction in practice.

4.34 There is also growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability, and especially on executive brain function (which includes working memory, mental flexibility, and self-control and regulation), which in turn impacts on mental capacity. People with frontal lobe damage caused by alcohol use, traumatic experiences or vitamin B1 deficiency may persist with risky and harmful behaviours for longer. They may also be less responsive to negative outcomes, and although they might have the mental capacity to predict what might happen, are less likely to be able to take action to prevent it from happening.

4.35 These cognitive deficits are unlikely to be detected using the verbal reasoning tests frequently used in Mental Capacity Assessments. No formal assessments of The Adult's mental capacity were recorded. For example, on 26 August 2020, no mental capacity assessment was made since The Adult was not ready for discharge from hospital. The Adult, however, was judged to lack the mental capacity to make decisions about his care and treatment and where he lived, and Deprivation of Liberty Safeguards (DoLS) were used to keep him at the care home if he tried to leave.

4.36 **Korsakoff's and Aggressive Behaviour**

4.37 The relationship between Korsakoff's Syndrome and aggressive behaviour is well established in the academic literature (for example, Yudofsky et al, 1984). The most frequent consequences of Korsakoff's Syndrome are anxiety and aggressive/agitated behaviour, followed by depressive symptoms. Aggressive behaviour has been reported to be prevalent in 20% (Wilson et al., 2012) and up to 54% (Ferran et al., 1996) of people with Korsakoff's Syndrome. Restlessness and agitation were prevalent in 10.4% of patients (Schepers et al., 2000). Violence and aggression associated with Korsakoff's is often unpredictable and intense enough to result in physical injury, either to victims or to the person with Korsakoff's Syndrome themselves.

4.38 Responses to this violence and aggression, and to the cognitive impairments associated with Korsakoff's Syndrome are, however, not well developed (Johnson and Fox, 2018) and are likely to involve combined behavioural and pharmacological interventions.

4.39 The significance of Wernicke-Korsakoff's Syndrome, the awareness of it and responses of services to The Adult will be considered in this report.

4.40 **Mental Health Act leave**

4.41 The Adult was granted Section 17 leave to move to the care home. Section 17 of the Mental Health Act 1983 (amended 2007) makes provision for certain patients who are detained in hospital under the Mental Health Act 1983 to be granted leave of absence from hospital. It provides the only lawful authority for someone detained under the Mental Health Act to be absent from hospital.

Section 17 leave can only be authorised by the medical officer responsible for an individual's care and treatment in hospital (the Responsible Clinician) and must be planned in advance with a Section 17 Form detailing the dates and times of the leave, and any conditions that apply. There is discretion to delay leave if, for example, the person becomes unwell, and if someone fails to return from leave then the Mental Health Act requires that they are brought back to hospital. Leave can also be revoked at any time and the person brought back to hospital. Luther King Ward at Lambeth Hospital contacted the care home each week for an update on how The Adult was, and The Adult's leave was to be reviewed on 5 January 2021.

4.42 Section 17 leave is not an alternative to discharge, and if the leave is for seven days or more, the Responsible Clinician must consider whether a Community Treatment Order is more appropriate.

4.43 The use of Section 17 leave will be considered in this report.

4.44 **CQC Registration and Age**

4.45 The Adult was granted Section 17 leave to move to the care home, a service registered with the CQC (Care Quality Commission). The CQC is the care and health sector regulator, and derives its powers from, and was established by, the Health and Social Care Act 2008. These have subsequently been extended by the Health and Care Act 2022. Providers of health and care services regulated by these Acts of law must register with, maintain the standards set, and be inspected by the CQC.

4.46 According to the Care Quality Commission, the care home is registered to provide the regulated activity of accommodation for persons who require nursing or personal care. The Care Home provides care and accommodation for up to 34 older people, and some people living with dementia. A CQC inspection report in 2010 stated that the care home provided accommodation for people aged over 65 years of age.

4.47 Providers of services registered with the CQC have a legal duty (under Regulation 12 of The Care Quality Commission (Registration) Regulations 2009), to provide a Statement of Purpose which contains, amongst other things, information about the types of service user the provider intends to provide a service for. These are called "Service User Bands".

4.48 The statutory context for the provision of Service User Bands is in Schedule 3(2) of The Care Quality Commission (Registration) Regulations 2009, which states that information to be included in the Statement of Purpose by the provider must include, *"The kinds of services provided for the purposes of the carrying on of the regulated activity and the range of service users' needs which those services are intended to meet."*

4.49 Upon receiving notification from a provider of a change in the types of service users that it intends to provide a service for, the CQC will consider whether there are any concerns about the ability of the provider to meet the needs of service users falling within the Bands. The CQC may obtain further evidence such as requesting information from the provider about how those needs would

be met, speaking to local commissioners and carrying out an inspection. If the CQC is concerned, on the basis of the information it has received, that the provider cannot meet the needs of individuals within that Service User Band, it can take further action, including, for example, adding a condition to the registration to restrict Service User Bands or Service Types.

4.50 The CQC confirmed that the care home changed its Statement of Purpose in 2018 to include the Service User Band of *"mental health"* but did not notify the CQC of the Service User Bands of *"mental health",* or *"younger adults"* (which covers 18-65 years old) until 25 May 2021 after both Eileen Dean and The Adult had moved to the Care Home.

4.51 Consequently, when Eileen's family agreed that she should live there, the Care Home had not notified the CQC that it had added the Service User Bands of *"younger adults"* or people with *"mental health"* needs to its Statement of Purpose.

4.52 This is significant since family members and commissioners may consider Service User Bands when making decisions about placements in services, since they provide information on who else might be placed there, and on the ability of the service to meet the needs of their family member or client.

4.53 Care services must (Regulation 12 (Schedule 3) of The Care Quality Commission (Registration) Regulations 2009) notify the CQC of the Service User Bands they wish to be registered for, and of any changes to these bands. Whilst the CQC will conduct competence and suitability checks to ensure that the service can meet registration standards, it is the responsibility of those making placements to reassure themselves that the care provider can deliver the service required.

4.54 According to the CQC, there is no automatic bar on a provider meeting the needs of an individual simply because they fall outside a Service User Band on the provider's Statement of Purpose. Individuals, particularly those with complex needs, may often fall within several different Service User Bands concurrently. It is therefore a matter for those placing the individual, as well as the provider, to assess the needs of the service user and satisfy themselves that the placement is safe and appropriate for the assessed needs of that individual.

4.55 CQC Service User Bands feature a distinction between those under 65 years of age and those over 65, although some care homes will accommodate and support both age groups. Intuitively, and suggested by the ONS (Office for National Statistics), this distinction would appear to be based on the male state pension age between 1925 and 2007 and before planned increases to 68 years old were announced.

4.56 The threshold of 65 years might suggest a smooth transition, but this is not necessarily the case. According to the ONS, people are living longer, healthier lives. Significantly the age of 65 years old is not directly comparable over time; someone aged 65 years today has different characteristics, particularly in terms of their health and life expectancy, compared with someone the same age a century ago.

4.57 The average age of people in care homes is 80 years old (The Lancet, 2022), suggesting that the majority of people in care homes will be at least some 15 years older than people below the age of 65 years. People over the age of 80 years old in care homes also have greater frailty and higher care needs. The care home noted during the negotiations that led to The Adult's leave, that The Adult would be 20 years younger than the other residents there. The care home did, however, have one woman resident who was approximately the same age as The Adult.

4.58 The ONS found that in 2011, 214,000 women and 77,000 men aged 65 years and over lived in residential care homes. Care home residents are predominantly female by a ratio of approximately 3:1. Of the 214,000 women, 138,000 were aged 85 years and over, almost twice as many as the entire population of men aged 65 years and over.

4.59 There has been a significant improvement in the health of men over the past 25 years. For men, levels of poor general health at the age of 70 years old in 2017 were the same as for those aged 65 years in 1997, while levels of limiting longstanding illness were similar to those aged 57 years old in 1997.

4.60 This suggests that regulators, providers and commissioners should be aware of the demographic age and gender profile in care homes and of the changes in the prevalence of poor general health and limiting conditions. There would appear to be a more significant difference between those aged 65 years and under and those aged over 65 years old than just one year of age. A man below the age of 65 years is most likely to be placed with women over the age of 85 years old who are frail.

4.61 There is also international evidence of resident to resident aggression and violence in care homes (for example, Botngård et al, 2020; Smith et al, 2018; Rosen et al, 2009), and SCIE (Social Care Institute of Excellence) has published: Resident-to-resident harm in care homes and residential settings. This reviewed the literature and provides guidance on identifying risks of, and intervening in, what it terms resident on resident abuse (RRA). The findings of this report are transferrable to other institutional settings, and concluded that all incidents of abuse between residents should be reported and recorded under local safeguarding procedures.

4.62 The SCIE review identified that in the majority of incidents of RRA, the perpetrator was a man with a cognitive impairment yet with high levels of what was described as cognitive awareness and physical functionality and a history of aggressive behaviours. The Adult would appear to meet these criteria. The victims of RRA were most likely to be cognitively impaired women, who had a history of wandering, were verbally abusive and behaved in socially inappropriate ways. Eileen Dean met these criteria only in terms of being a woman with dementia. High levels of dependency and the need for high levels of support were identified in the research as protective factors, but did not safeguard Eileen from The Adult who was able to move around the care home freely and enter residents' rooms. Most incidents of RRA took place in the evening or at night, presumably when staffing levels were lower and there were fewer organised activities.

4.63 The relevance of service user bands, demographics and the research on RRA for commissioning, making placements and for standards and quality monitoring will be considered in this report.

4.64 **Impact of Covid-19**

4.65 The events covered by this SAR took place within the context of the global coronavirus pandemic (Covid-19) and the responses to its concerns about the worldwide coronavirus pandemic began in January 2020 and on 29 January 2020 the first two people in the UK tested positive for the Covid-19 infection. More cases followed and it became evident that restrictions on liberty were likely to be introduced to reduce the spread of the virus and protect people who were especially vulnerable to it. Restrictions were initially focused on people who had contracted the virus but on 23 March 2020, the government restricted contact between households and the UK population was ordered to *"stay at home".* The only permissible reasons to leave home were food shopping, exercise once per day, meeting medical needs and travelling for work when absolutely necessary. All shops selling non-essential goods were told to close and gatherings of more than two people in public were banned. These 'lockdown' measures legally came into force on 26 March 2020. They did not begin to be lifted until 10 May 2020.

4.66 The Adult was admitted to UHL on 10 July 2020 and discharged to the Ladywell Unit on 15 September 2020. During this time, Covid-19 infection rates had started to increase and restrictions began to return in September 2020. A localised tier-system of restrictions on movement and association was introduced on 14 October (London was in Tier 4, the highest tier) and a second national *"lockdown"* was imposed between 5 November and 2 December. During this period, Eileen Dean was at the care home and The Adult was in Lambeth Hospital.

4.67 The second national lockdown was followed by the reintroduction of an enhanced tier system, with Southeast England and London placed in the most restrictive Tier 4 *"Stay at Home"* restrictions from 21 December. The Adult moved on Section 17 leave to the care home on 22 December 2020. Amongst the restrictions was no visiting care homes. Eileen Dean was killed by The Adult on 4 January 2021. A third national lockdown was introduced on 6 January 2021.

4.68 Restrictions on movement were not the only consequences of Covid-19 and the response to it. Throughout the Covid-19 lockdown, face to face contact between practitioners stopped or was significantly curtailed and some services closed entirely. Nationally, staff in health and social care were redeployed from specialist to more generalist work to support the Covid-19 effort and it is likely that there was an impact on the workload, ways of working, availability and accessibility of staff in Lewisham. Visits to hospital wards and care homes were reduced and the social worker who arranged The Adult's discharge did not visit the wards as often as usual due to Covid-19.

4.69 Staff were self-isolating, in accordance with government guidance, reducing the number of staff available to meet increasing demand. Face-to-face contact

decreased yet demand for services, sometimes to replace those that had been closed or limited by other agencies' responses to coronavirus, increased.

4.70 The impact of the coronavirus pandemic, and the restrictions in response to it, on the services working with Eileen Dean and The Adult will be considered in this report.

5. THEMATIC ANALYSIS AND FINDINGS

5.1 The Adult's Wernicke-Korsakoff's Syndrome and Aggression

5.2 The Adult had been admitted to a general medical ward at UHL on 11 July 2020 following alcohol withdrawal seizures. The Adult also had mobility needs and walked with the aid of a stick. Between admission on 11 July and 5 August, there were no recorded incidents of The Adult behaving in an aggressive or threatening way, a period of 26 calendar days.

5.3 Between 5 August 2020 and 4 September 2020, however, there were at least thirty-four recorded incidents of violence or threats to patients or staff, which occurred on twenty-three occasions on fourteen days. Several of these occasions involved more than one incident, and on one day (26 August 2020) there were six occasions involving eight incidents of threatening or aggressive behaviour. In response, from 5 August 2020, The Adult received support from an RMN who remained with him throughout the day and night. Hospital security were called a number of times to intervene with The Adult. The RMN's role was to reassure The Adult (and ward staff) and to de-escalate aggressive situations using Psychological Skills Training techniques, but the RMN also resorted to physical interventions with The Adult to prevent harm to himself or others. The social worker who arranged The Adult's placement at the care home later explained to the care home that they had been told that these incidents were associated with The Adult's admission to hospital. They actually occurred 26 days afterwards. By this time any detoxification from alcohol would have been completed.

5.4 At least three of these incidents involved The Adult using knives (described as bread or butter knives), scissors or dinner trays as weapons. In one incident, The Adult was found holding a pair of scissors which were taken from him. It is unclear what was done to restrict The Adult's access to these objects.

5.5 There were at least three incidents when The Adult expressed paranoid thoughts about staff and patients. These included one incident when The Adult said that he believed that the RMN was going to kill him and another incident, the next day, when The Adult threatened to kill the RMN.

5.6 There were at least four incidents when The Adult threw items, often jugs of water or cups, at staff or patients.

5.7 There were at least ten incidents when The Adult smashed equipment ranging from ward computers to a radio and the crash trolley.

5.8 There were at least ten incidents when The Adult was described as agitated, angry, abusive or aggressive towards patients or staff.

5.9 There was at least one incident when The Adult grabbed the RMN, who had to use breakaway techniques.

5.10 There were at least four incidents when The Adult made threats.

5.11 Despite this intense period of incidents, no formal risk assessments were recorded. LGT did not complete a risk assessment or collate information about the incidents, which had been recorded on a shift-by-shift basis between 5 August 2020 and 4 September 2020. Had this been done, SLaM may have had a clearer picture of The Adult's behaviour when he was transferred to the Ladywell Unit. Whilst SLaM did use a risk assessment form, it was not completed correctly and was not informed by up-to-date information. It appears that no attempts were made to analyse each incident to, for example, determine what the antecedents and consequences were, and how these related to The Adult's behaviours. Other than occasional notes that The Adult was agitated and was not sleeping, no contextual information was recorded to help to identify and understand what might be associated with The Adult's behaviours. Such approaches may be beyond the skill set of a general medical ward but should not be unfamiliar to mental health services. The role of the RMN does not appear to have included gathering and analysing information, which may have assisted in understanding, predicting or preventing The Adult's violent and aggressive behaviours. To reduce risk, the general medical ward gave The Adult plastic rather than metal or ceramic cutlery, but this did not prevent access to scissors or other forms of equipment.

5.12 None of these incidents were reported to the police as it was assumed that his aggression was mental health related, although he was not sectioned under the MHA until 3 September 2020. The assumption was that no charges could be made because of The Adult's mental health state. This minimised the level of The Adult's threatening and violent behaviour; threatening another person with a dangerous weapon can result in a period of imprisonment. It also second-guessed the actions that the police might take. This prevented police intervention with The Adult, which might have warned him that if he continued to act in a threatening or aggressive way, he might be arrested.

5.13 There may also have been some evidence that The Adult responded to legally escalated interventions. When The Adult was placed on a Section of the Mental Health Act on 3 September 2020, incidents of violent and aggressive behaviour ceased to be recorded after 4 September 2020 even though he remained on the general medical ward until 15 September 2020.

5.14 It is more likely, however, that an increase in antipsychotic medication played a role in this. Whilst on the general medical ward, The Adult was given 25mg of Quetiapine (an anti-psychotic) at night from 27 August. This was progressively increased to 50mg on 1 September and then to 100mg on 4 September. By 7 September The Adult's behaviour was noted to have settled. Despite this improvement, the dose of Quetiapine was increased again to 150mg on 11 September and then to 200mg on or around 15 September, at which it remained whilst The Adult was on leave at the care home.

5.15 Since incidents had not been reported to them, the police were unaware of The Adult's behaviours and could not search on local and national databases to find out whether or not The Adult had a previous offending history. This history was only discovered after The Adult had assaulted Eileen Dean.

5.16 No incidents were reported as adult Safeguarding Concerns, despite the fact that there were serious incidents on the general medical ward at UHL between 5 August and 4 September 2020 where other patients (with care and support needs) had been subjected to, or witnessed the violent, threatening and aggressive behaviour of The Adult. Even if this had led to a decision that no adult Safeguarding Enquiry was required, it would have required more detail to be gathered on each incident and might have increased awareness of the frequency and intensity of The Adult's behaviour within LGT, SLaM and Lewisham Council.

5.17 There were some attempts to talk to The Adult about why he was behaving in this way, but these do not appear to have been part of a consistent approach or structured intervention. The Adult told a psychiatrist on 10 August 2020 that he had experienced mental health problems in the past and was, a *"lunatic"* who had *"done bad things*". The Adult was unable to elaborate further on this and said that he had previously seen a psychiatrist but was unable to recall when or for what reason. The Adult agreed that he had a problem with his memory, which he said was new.

5.18 The Adult had a UTI (Urinary Tract Infection) when on the general medical ward, which may have caused his anxiety and confusion. He had a catheter fitted which, between 11 July and 19 July, drained dark and occasionally bloody urine. Between 11 July and 5 August, however, there were no reports of any incidents of threatening or aggressive behaviour. From 25 August the infection was described as asymptomatic.

5.19 The Adult's behaviour was thought to be related to his UTI and delirium. On 12 August 2020 The Adult said that he was in a *"war-like"* game and that he might need to kill to defend himself.

5.20 The Adult also explained to the OT that, "*I force loneliness on myself as a form of self-harm for all the bad things that I have done".* The OT's report stated that The Adult did not feel lonely but felt safer alone than in the presence of other people.

5.21 These statements by The Adult might have provided some insights into his behaviour and paranoia. It may also have hinted at potential risks to other people due to The Adult's fears for his own safety. On 26 August 2020, The Adult had said that the staff on the general medical ward had taken all his belongings from him. When they explained that The Adult's belongings were being kept safe, he responded violently by destroying the combined television and telephone by his bed. The Adult also said that he was fearful that the RMN was going to kill him, and one of the eight incidents on 26 August involved The Adult threatening to stab anyone who came near him with a pair of scissors. The Adult's threatening and aggressive behaviour may have been associated with his feelings of paranoia and fear.

5.22 The OT assessments on 18 September and 24 September 2020, which were conducted whilst The Adult was on Powell Ward at the Ladywell Unit, noted that, *"The Adult's predominant issues are his cognitive impairment, delusional beliefs and aggression"*. However, from the mental health service perspective, The Adult's alcohol dependency was considered to be the key factor and it does not appear that any underlying mental health needs were explored further. The Adult's presentation was judged by SLaM to be consistent with that expected from someone with alcohol induced Wernicke-Korsakoff's Syndrome, and not with the Bipolar Disorder with which The Adult had been previously diagnosed, and which had been noted in The Adult's patient records by LGT. SLaM however, also stated that Wernicke-Korsakoff's Syndrome was a rare diagnosis, implying that it was not one that its practitioners had great familiarity with, despite also being a provider of services for people who were substance dependent.

5.23 The Adult was described as requiring support with the *"activities of daily living"* within the context of Wernicke's-Korsakoff's Syndrome, which was understood to be a form of dementia. Even if Wernicke's-Korsakoff's Syndrome was understood to be a form of dementia, this did not mean that The Adult could not also have mental health needs (Onyike, 2016).

5.24 Whilst Wernicke's-Korsakoff's Syndrome is described as being similar to dementia in its causes, the treatment and prognosis are different from those of, for example, Alzheimer's or Vascular Dementia. The Korsakoff's stage is sometimes also referred to as a *"psychosis"* (for example, Chandrakumar et al, 2018). It would appear that the labels of dementia and psychosis in Wernicke's-Korsakoff's Syndrome are essentially descriptive rather than diagnostic. They did not imply any similarities in causation or treatment and prognosis.

5.25 On reflection as part of this SAR, there was a recognition that a conclusion had been reached by SLaM that The Adult's threatening and aggressive behaviours were the result of his use of alcohol, and when he was not using it, to be a response to his environment or the effects of a UTI. There appears to have been a multiplication of suggested causes, but The Adult's mental health state was not considered to be an independent factor. This suggests that the theme identified by Alcohol Change UK (see Appendix 3) in other SARs in 2019, of an over-reliance on alcohol to explain The Adult's presentation, was present. Despite this, there appears to have been only one attempt, to discuss The Adult with specialist substance dependency services. On 28 July 2020 the hospital social work team at UHL contacted Change Grow Live (CGL – a specialist provider of services for people who are substance dependent) and were advised to contact them again two to three days prior to The Adult's discharge to arrange an assessment for his aftercare needs. This was before The Adult was recorded as behaving in a threatening or aggressive way and he was admitted to the Ladywell Unit.

5.26 Incidents of aggression or violence were not recorded on any of the hospital wards between 5 September 2020 and 22 December 2020 but there were still events for which risk assessments might have been appropriate. For example, whilst on SLaM wards, The Adult was noted to have made threatening gestures with his walking stick. The Adult was also reported to have become distressed, anxious, confused and tearful when he was told that he could not return to

Powell Ward, from Florence Ward, when he had recovered from Covid-19. This might have suggested that The Adult found transitions difficult and could have been recorded in a risk assessment. Instead, The Adult's anxiety was not considered unusual in the context of his clinical presentation.

5.27 In summary, between 5 August 2020 and 4 September 2020 whilst on a general medical ward at UHL, there were at least thirty-four record incidents of The Adult behaving in a way that was violent or threatening to patients or staff. Incidents of threatening behaviour continued when The Adult moved to the SLaM wards. These were not reported to the police, or to Lewisham Council as adult Safeguarding Concerns, even though some involved the use of weapons. No attempts were made at the time to discover if The Adult had a history of contact with the criminal justice system. The Adult also showed signs of paranoia, fear and anxiety. No formal analysis of these incidents to better understand, predict or prevent them was made, and no formal risk assessments were formulated by either of the NHS Trusts involved in managing The Adult's care and treatment. The Adult's threatening and aggressive behaviour was ascribed to a number of causes: Wernicke-Korsakoff's Syndrome and alcohol use, a response to his environment, or the effects of a UTI. Underlying mental health needs were not considered, despite there being evidence that The Adult had once been diagnosed with Bipolar Disorder.

5.28 **Discharge Planning**

5.29 The Adult's discharge planning appears to have begun on 3 August 2020 with an action for a UHL Occupational Therapist (OT) to contact The Adult's next of kin, to initiate discharge planning discussions. At this time The Adult had not been recorded as behaving in a threatening or aggressive way.

5.30 From 5 August 2020 until 4 September 2020, however, there were repeated incidents recorded involving threats and aggression by The Adult. On 10 August 2020 a request was made by LGT for a social worker to be allocated urgently due to The Adult's behaviour and his social circumstances (the notes do not make clear exactly what this meant). There is no record that the social worker and the OT discussed The Adult.

5.31 On 12 August 2020, a nurse on the general medical ward at UHL spoke to the social worker to start the discharge process. At this stage, The Adult's discharge destination was unclear and was dependent on the outcome of The Adult's psychiatric assessment. The Adult remained on the general medical ward under Deprivation of Liberty Safeguards, which prevented him from leaving.

5.32 By 26 August 2020, it was becoming clear that The Adult would not be able to return home to his bedsit due to his current cognitive problems and the risk he posed to himself, and others. On this day there were six occasions involving eight incidents of threatening or aggressive behaviour. On 28 August 2020 the nurse and social worker proposed that The Adult be considered for a *"complex"* discharge.

5.33 In this context *"complex"* meant non-standard, and so different from the usual pathway for discharge arrangements from hospital to home. The 'usual', non-complex pathway, involves commissioning a service from a range of home-based and residential care providers, depending on assessed needs and service capacity. If appropriate to a person's abilities and needs, reablement services could be commissioned to enable them to regain their independence.

5.34 Complex discharge, however, meant that The Adult would not return home and would not be discharged through this usual pathway. There was no expectation that The Adult would be rehabilitated sufficiently to return home due to his Wernicke-Korsakoff's Syndrome.

5.35 Since The Adult was not going home, six residential care homes were approached. Two had no vacancies, one rejected The Adult's referral, but three were willing to consider The Adult. Of these it appears that the care home was the only provider to assess The Adult.

5.36 Consequently, the residential discharge options for The Adult were limited to the care home. There are no services specifically for people with acquired conditions such as Wernicke-Korsakoff's Syndrome in Lewisham and it does not appear that a search was made for suitable services elsewhere. The usual pathway for finding and allocating care providers was also not applied due the *"complex"* nature of The Adult's discharge. No contact was made with CGL despite its offer on 28 July 2020 to assess The Adult before he was discharged.

5.37 **Moves Between Wards**

5.38 On 3 September 2020, however, The Adult was detained under Section 2 of the Mental Health Act. This allowed The Adult to be held in hospital for up to 28 days whilst his mental health condition was assessed. Despite this, The Adult remained on the general ward waiting for a bed in the Ladywell Unit, where he transferred to Powell Ward on 15 September 2020. The Ladywell Unit is an inpatient mental health service at UHL. It is provided by SLaM, although at the University Hospital Lewisham, which is run by the Lewisham and Greenwich NHS Trust. Consequently, The Adult's transfer to the Ladywell Unit involved a transfer between two NHS trusts.

5.39 The discharge letter from the general medical ward at UHL to The Adult's GP on 15 September 2020 noted that The Adult's discharge destination was *"High Security Psychiatric"*. The letter noted that The Adult had received one to one supervision because his behaviour had been challenging and difficult to manage, with episodes of verbal and physical aggression to staff (the letter did not mention patients). The letter noted growing concern after The Adult had tried to stab a doctor with a knife, had smashed computers and thrown drinks.

5.40 On Powell Ward, The Adult was identified to require intensive support to maintain his personal care and to engage in activities that were personally meaningful and enjoyable for him. It was not a High Security Psychiatric service and according to SLaM, The Adult was not assessed to require a PICU. The Adult was also considered likely to require support in maintaining his personal living space and doing laundry. These were all familiar support needs with the *"activities of daily living"* and there does not appear to have been consideration

of the need for on-going mental health support. The Adult's discharge arrangements consequently focused on obtaining residential care for him, and on the 26 November 2020, the care home received a referral from the Ladywell Unit to assess The Adult's suitability for a placement.

5.41 On 2 December 2020, whilst at Powell Ward on the Ladywell Unit, The Adult contracted Covid-19 and became unwell. He was transferred to Florence Ward at Lambeth Hospital on 4 December. Lambeth Hospital is a mental health service. Like the Ladywell Unit it is provided by SLaM, but at a different location approximately seven miles away. Florence Ward was designated as a Covid-19 ward and The Adult remained there until 17 December 2020 when he had recovered sufficiently from Covid-19.

5.42 No beds were available for The Adult to return to Powell Ward at the Ladywell Unit, so The Adult moved to the Luther King Ward, still at Lambeth Hospital. Within a period of almost three months, The Adult had moved between four hospital wards, three of which were mental health wards, on two different sites, one in Lewisham and the other in Lambeth, and two NHS trusts. The Adult and the services supporting him also experienced several changes and transitions in the process.

5.43 The Adult remained on Luther King Ward until he moved to the care home on 22 December 2020, following a meeting that same day, on Section 17 Mental Health Act leave for two weeks. This was to be reviewed on 5 January 2021.

5.44 Alternative discharge or leave arrangements do not appear to have been explored. The Adult was thought to be unable to return home due to his needs and risk to others, and it does not appear that home-based support was considered for him. A Community Treatment Order (CTO) should be considered if someone is on Section 17 leave for more than seven days. SLaM judged a CTO to be unsuitable for The Adult. He had Wernicke-Korsakoff's Syndrome which SLaM considered to be a form of dementia, rather than a mental health problem, and consequently a community mental health team would be unable to meet his needs. The Adult had been referred to the Lewisham Enhanced Recovery Community Team, which had declined him due to his chronic cognitive impairment, which was unlikely to improve and would be better managed by the Lewisham Mental Health Older Adult's Team.

5.45 There does not appear to have been consideration that consultation with, or referral to, a practitioner or a team skilled in working with people with acquired dementia, or with substance dependency, might have identified more options; and provided a more specialist assessment of The Adult's needs and the risks that he posed to himself or others. This was a missed opportunity.

5.46 On 24 December 2020, after The Adult had moved to the care home on Section 17 leave, a SLaM doctor sent an email referral to the Lewisham Older Adults Mental Health Team for support for The Adult. This described what was known about The Adult and stated that there had been reports of incidents of aggression towards, and assaults on staff, but that most recently The Adult had not been aggressive and was instead confused by his circumstances. The Lewisham Older Adults Mental Health Team was unable to accept the referral because The Adult did not have dementia, but had Wernicke-Korsakoff's

Syndrome's resulting from alcohol use, which was an acquired brain injury. Consequently, The Adult moved to the care home without any specialist support. Given The Adult's diagnosis and the lack of understanding of why he had behaved in an aggressive and threatening way, specialist support should have been identified for him prior to Section 17 leave.

5.47 **The Adult's Fears on the Wards**

5.48 During one of the visits by the care home to The Adult at the Ladywell Unit on 26 November 2020, it was noted that The Adult, *"keeps himself to himself, appears anxious and intimidated by younger and louder patients on the ward"*, a view that the director of the care home shared. Covid-19 restrictions had meant that there was less leave available for patients and this increased tension on the wards. On reflection as part of this SAR, The Adult was considered to not fit within a mental health service since he had a dementing illness with persecutory delusions. The Adult might have felt intimidated by younger and more mobile people, but might have been more assertive and dominant in an environment where he was with people less able and vulnerable than he was.

5.49 The lack of a formal risk assessment and formulation which included the reasons why The Adult had behaved in a threatening and aggressive way, meant that how he might behave in different environments, with different people, was not explored.

5.50 There was a recognition during the SAR process that the SLaM approach to formulating risks needs to be further developed. In The Adult's case the relevant form was not properly completed.

5.51 In summary, The Adult's discharge arrangements from hospital did not follow the usual pathway since he was not returning home, and there was little expectation that he would recover. Within a period of almost three months, The Adult had moved between four hospital wards, three of which were mental health wards, between two different hospital sites and two NHS trusts. He was described as confused and anxious, and was considered to have a form of dementia rather than mental health needs, but no specialist input with this was sought. Both the Lewisham Enhanced Recovery Community Team and the Lewisham Older Adults Mental Health Team had rejected The Adult's referral to them because he did not meet their criteria. Accommodation and support options were limited to the care home, which supports people with dementia, and no specialist services for people with acquired dementia or alcohol use related needs were considered.

5.52 The Adult was placed on Section 17 leave and his clinical needs were to be managed from Luther King Ward at Lambeth Hospital, where he could be recalled to.

5.53 **Local Care Home**

5.54 The care home is registered with the CQC to provide accommodation for persons who require nursing or personal care. However, it had not notified the CQC that it had added the Service User Bands of younger adults and people

with mental health needs to its Statement of Purpose when The Adult, who was 62 years old and had mental health needs, was placed there. The care home notified the CQC of these Service User Bands on 25 May 2021.

5.55 Despite this, the care home had admitted twelve people from psychiatric settings between 2012 and 2020, in addition to The Adult. These twelve placements were understood by the care home to have been successful, which believed that it had the competence to support The Adult on the basis of the information it had received about him, and the outcomes of its own visits to The Adult, and the assessments that had been conducted. This belief was shared by commissioners and by referrers. However, the care home was not a mental health service, and could not treat mental health problems or acquired brain disorders, nor had it notified the CQC that it had added the Service User Band of people with mental health needs to its Statement of Purpose. It appears that SLaM believed that the Registered Manager (whom SLaM referred to as the "Deputy Manager") of the care home was an RMN (Registered Mental Nurse) but they were not. Instead, they held a level 5 NVQ qualification in social care management. Neither the Registered Manager nor the Director of the Care Home were qualified RMNs.

5.56 The care home had been made aware that The Adult had behaved in a threatening and aggressive manner when he had first been admitted to hospital, but were assured that The Adult no longer posed a risk. It would appear that the care home did not claim any special competence in supporting people with mental health needs or with Wernicke-Korsakoff's Syndrome, and that the care home was clear that it could not manage The Adult if he became aggressive.

5.57 Despite this and the lack of risk assessment, and analysis of the reasons why The Adult had behaved in a threatening and aggressive manner whilst on the general medical ward at UHL, The Adult was placed at the care home. The only risk mitigation in place appears to have been the use of Section 17 leave, which allowed The Adult to be returned to hospital if this was considered necessary.

5.58 The assessment process which led to The Adult moving to the care home appears to have begun on 24 November 2020. The Director of the care home received a copy of the OT report of 18 September 2020, which noted that The Adult's had most likely progressed to Korsakoff's as there had been little improvement and he had become increasingly aggressive, had damaged hospital property and had assaulted staff. The report also recommended that The Adult required a placement for people with memory impairments and intensive support to maintain a personal care routine and to engage with activities that he enjoyed but that The Adult should be given some level of autonomy to, for example, make food and hot drinks.

5.59 The Director of the care home also received a Powell Ward care plan and risk assessment dated 20 November 2020, which stated that The Adult did not present a current or historical risk of violence and aggression and that there was no recording of historical risk on the patient records, or a current risk or historical risk of domestic violence and abuse. The Adult's risk to others, assessed on 16 September 2020 was rated as low. The Adult was described

as calm and cooperative and never threatening or hostile even when he was challenged about some (unspecified) remarks he had made. The assessment also stated that The Adult's UTI could explain his physical/ challenging behaviour. The care plan and risk assessment had failed to recognise the events on the general medical ward at UHL, operated by LGT, and that The Adult had continued to use his walking stick in a threatening way whilst on the Ladywell Unit operated by SLaM.

5.60 In the light of these reports, The Adult was assessed by the Director of the care home on 26 November 2020, the content and outcome of which was confirmed in an undated letter. This raised the care homes' past experience of the difficulty of removing a resident from the care home if their placement was breaking down, or there were risks, including aggression, which could not be managed. The care home received reassurance from the social worker that full support would be provided if this happened with The Adult.

5.61 The care home stated that it had cared for people under 65 years old and had not experienced age-related difficulties but identified that The Adult was younger than nearly all other residents by 20 years or more. The social work integrated assessment had identified the risk of physical violence in a tick-box, but had not provided further details on this. The Director of the care home restated that The Adult had been aggressive on the general medical ward at UHL, and the care home could not manage a 62-year-old man who posed any risk of aggression. If The Adult was no longer aggressive and was willing, then the care home could offer him a placement.

5.62 The social worker had been assured that this had been an isolated incident associated with The Adult's admission to the general medical ward and explained that The Adult posed no risks. The Director of the care home, according to their letter, pressed further on this and asked to speak with a doctor. The Director of the care home then discussed The Adult's behaviour with a (junior) doctor familiar with The Adult. The Director of the care home noted that the doctor was clear that The Adult would not present any sort of threat to the care home staff or residents.

5.63 The Director of the care home emailed the social worker the same day confirming that The Adult would need one-to-one care for two weeks due to his confusion, memory difficulties and the change in environment and *"company".* This had been tried successfully with two previous placements. Fee and placement negotiations followed with further emails on 23 December 2022 after The Adult had moved to the care home. None of these emails discussed The Adult's care needs, risk assessments or risk management plans.

5.64 No formally recorded risk assessment or risk management tools appear to have been used for the placements of either Eileen Dean or The Adult at the care home by SLaM or by commissioners.

5.65 The care home completed an undated narrative risk assessment of The Adult which noted *"risks to be aware of".* These were his cognitive impairment, delusional beliefs and aggression. The Adult had not attended to personal care during his first week in the Ladywell Unit despite staff prompts, and said that he was just *"passing through".* When reminded that he would be there for at least

a few days, The Adult had become distressed and verbally aggressive and had made threats that he would send the Army to *"blow the hospital up".*

5.66 The care home noted that The Adult was scared by his lack of memory and was disorientated by the changes in environment. The care home's 'Behaviours that may Challenge Care Plan One-to-One, dated 26 December 2020, noted that, The Adult's initial behaviour in hospital nearly four months ago, had been aggressive and that he had attacked a doctor, but that since his treatment had commenced, and since his time on the Ladywell Unit, *"we are assured that he has been quiet and non-aggressive".*

5.67 Between 23 and 26 December 2020, one-to-one support for The Adult was commissioned from the care home to help him to settle in rather than to manage his behaviour. No additional support was provided to The Adult at night-time and two members of staff were on duty as usual for all residents. The care home had been told that The Adult slept well, although this had not been the case when The Adult was on the general medical ward at UHL, during which time he was supervised by an RMN. In hindsight, one to one night time support may have been appropriate due to the still uncertain risk of The Adult behaving in an aggressive and threatening way and may have intervened when he was in the corridor on 4 January 2021.

5.68 In summary, it would appear that the level of aggression displayed by The Adult on the general medical ward to patients as well as to staff, and which had necessitated both the presence of an RMN to provide support to The Adult and the attendance of hospital security staff, had not been made fully clear to the care home. Instead, the care home's risk assessment focused on aggression towards staff when demands were made on The Adult, and upon the rather grandiose threat that The Adult had made to blow up the hospital.

5.69 The Adult was at least 20 years younger than most of the other residents at the care home. Despite reduced mobility, he was more able than the majority of the other residents and much less frail and vulnerable. He moved to a room on the second floor in an annex where two elderly women lived, which was the only room that was available. He had been intimidated when surrounded by predominantly younger people on mental health wards. Due to Wernicke-Korsakoff's Syndrome The Adult may have appeared to have greater mental capacity than he actually had, although he was judged to lack the mental capacity to make decisions about his care and treatment and where he might live. The Adult appears to have retained a level of, what SCIE had described in its review of RRA as, cognitive awareness. At the care home, The Adult asked for, and was given access to a laptop computer. This was supervised by the Director who said that he had checked what activities The Adult used the laptop for, and found that he actually did very little with it, although it appears that The Adult left a message on Facebook suggesting that his mental health state was relapsing.

5.70 **Funding**

5.71 Health funded placements for people with mental health needs were delegated by the South East London (SEL) NHS Clinical Commissioning Group (CCG) (now Integrated Care Board) to SLaM. Lewisham Council did not delegate its

budget to SLaM, but its brokerage team do not place mental health clients. Care Co-ordinators are responsible for drafting assessments, identifying placements and liaising with providers based on the clients' needs. SLaM's Enhanced Recovery Team (Placement Team) team leader provides overall relationship management support for mental health care and nursing homes in Lewisham, and negotiates fees where required.

5.72 Despite this arrangement, The Adult was not considered to require a mental health placement. Instead, he was judged to have a form of dementia and had been rejected by the Enhanced Recovery Team since he was considered to be unlikely to recover.

5.73 Lewisham Council has an Integrated Placement Panel. This is a multi-disciplinary panel that is comprised of various operational and clinical leads from SLaM, the CCG and Lewisham Council. The Panel reviews assessment documentation, provides recommendations and approves placements for people in residential and nursing homes, or who are eligible for aftercare support under Section 117 of the Mental Health Act (1983). The panel does not meet the people it is considering services for.

5.74 On 4 November 2020, the Integrated Placement Panel asked the social worker to apply for Continuing Health Care funding for nursing care due to The Adult's significant cognitive decline. The Continuing Health Care Team concluded on 16 November 2020 that The Adult did not meet the threshold for Continuing Health Care funded nursing care. As a result, it appears that the only option then considered was residential care. There is no evidence of consideration of a specialist placement for people with an alcohol-related brain injury.

5.75 On 17 November 2020 the social worker's manager asked the Lewisham Council Integrated Commissioning Team to agree an Out of Panel Decision to secure a placement in a residential service that works with people with dementia, since The Adult needed to be discharged and placed before the next panel was convened. The social worker was asked to explore placements within residential services working with older people with dementia. Again, there is no evidence that a specialist placement for people with alcohol-related brain injury was considered.

5.76 On 26 November, The Adult was assessed by the care home and the social worker made a funding request for 1:1 daytime care for a two week transitional period. On 30 November 2020, the out of panel request for funding was approved.

5.77 **Placement Monitoring**

5.78 Placements at the care home were monitored by Lewisham Council in a joint commissioning arrangement with Lewisham CCG. A Contract and Quality Assurance (CQA) Officer monitored the care home, who was managed by a Joint Commissioner. The care home would usually receive two quality monitoring visits each year, but due to the restrictions imposed in response to Covid-19, quality monitoring was conducted virtually. There was no direct contact between the Joint Commissioning Team and the care home during the

period covered by this review. There was some virtual visual monitoring of the direct service delivery through the use of an iPad with a camera.

5.79 According to the Lewisham commissioners, the CQA Officers would not routinely know the names of residents, who had placed them in the service, and what the mix of the client needs, ages and genders was. This was prevented by General Data Protection Regulations. It was the responsibility of the Care Home to understand the compatibility of its residents. The Care Home had raised the matter of the difference between The Adult's age and that of the majority of other residents and had been assured that he was no longer behaving in an aggressive or threatening way. Eileen Dean was placed at the care home by another London borough so the CQA Officers and commissioners in Lewisham were unaware of her.

5.80 There had been two Safeguarding Enquiries following concerns raised at the care home in January 2020 and in May 2020. These concerned the care home not obtaining sufficient information about clients from their relatives before accepting them as residents. The recommendations from these enquiries, noted in the monitoring visit report, included the need to improve the *"pre-assessment"* process to ensure that the care home was able to fully meet the needs of clients it assessed. The format used for pre-assessments should be more detailed and should collect information about support needs, behaviour that challenges, and should directly address absconding risks. It was recommended that the care home should use the Quality Compliance System (QCS) pre-admission form, and should be trained in this by the SEL CCG (Lewisham) Safeguarding Nurse. The QCS includes questions about the need for risk assessments of, amongst many others, harm to others.

5.81 Following the death of Eileen Dean, the CQC conducted an inspection visit at the care home on the 26 January 2021 and 16 February 2021, the results of which were published on 20 April 2021. This identified the need for improvement in two of the five inspection standards: *"Is the service safe?"* and *"Is the service well led?".*

5.82 The CQC determined that the care home did not do all that was practicable to ensure that care and treatment was provided in a safe way, as risks to people were not always identified and mitigated. Areas identified included conflicting information about individual risk factors in care plans and risk assessments, inaccuracies in personal evacuation plans, and lack of clear documentation of choking risk for one resident. There was also no systematic way of reviewing and assessing staffing levels based on people's dependency and care needs. Staffing levels did not correspond with the level of support stipulated in people's personal evacuation plans, as several plans that were reviewed stated people would need the individual support of one member of staff to remain in their room in the event of an emergency. The staffing levels of two staff during the night made this overall level of support impossible.

5.83 Whilst a system was in place to record accidents and incidents, including falls, not all had been reviewed and analysed to learn from, and make improvements to reduce risk.

5.84 The care home had also failed to assess, monitor and improve the quality and safety of the service effectively, and had failed to ensure people received a consistently safe service. The quality assurance systems had not identified the inconsistencies in recorded information, and accident and incident monitoring had not identified trends and themes. There was no consistent way of assessing a resident's equality needs, and one incident of a serious pressure ulcer injury had not been reported to the CQC.

5.85 Some of these had been identified in the Lewisham Virtual Quality Monitoring report for October/ November 2020. Under care and support planning, the monitoring report identified the need for the care home to conduct audits of care plans to rectify errors and inaccuracies, and to update them when there were changes. The monitoring report also identified the need to improve meal choices, medication administration recording, and for improvements in staff management information, including supervision notes, and in recording training and development needs. The monitoring visit also identified the need for actions on health and safety. These concerned external maintenance contractors and improved recording of internal health and safety checks. They also included the creation of a quality assurance checklist to give the care home an overview of the areas where checks had been carried out, and to identify any gaps in record keeping and ensure action is taken by the service to address these. Areas included Medical Administration Record (MAR) audits, kitchen record audits, staff file audits, and maintenance check audits etc.

5.86 Professionals from a GP practice and SLaM had also been consulted about the quality of the service provided by the care home and were noted to have been very complimentary, while acknowledging the lack of detail in the recording of information. One of the professionals said that the care home was the place they would place their family member in.

5.87 **Quality Support and Development at the Care Home**

5.88 The care home accessed sources of information and advice by attending the Lewisham Provider Forum, which offers information exchange and peer support between provider and commissioners. Two provider forums were held virtually on 23 September 2020 and on 16 December 2020. The main topics of discussion at these meetings were fire safety, pharmacy support and the response to Covid-19. These meetings did not discuss placement practices, risk assessments or information sharing relevant to this SAR.

6. CONCLUSIONS

6.1 **The impact of The Adult's Wernicke-Korsakoff's Syndrome and the risk of threatening and aggressive behaviour was not well understood by services.**

6.2 The Adult had been in contact with SLaM in 2014 for alcohol use and had attended hospital for alcohol detoxification. The Adult now had Wernicke-Korsakoff's Syndrome as a result of alcohol use. This was described as a form of dementia by mental health services, but its cause, treatment and outcome were different from those other forms of dementia. The increased risk of violent

and aggressive behaviour, and the challenges of responding to it identified in the research, does not appear to have been understood **(Recommendation 1)**.

6.3 Since The Adult had Wernicke-Korsakoff's Syndrome because of alcohol use, there appears to have been little further consideration of whether he had any other underlying mental health needs. Despite an earlier diagnosis of Bipolar-Disorder, The Adult's presentation was judged to be consistent with that expected from Wernicke-Korsakoff's Syndrome or from a UTI. The Adult was identified as having paranoid thoughts and to feel threatened, but these were not considered beyond their connection with his alcohol use and alcohol induced cognitive problems.

6.4 There was little history available about The Adult and any previous incidents of threatening or aggressive behaviour before he assaulted Eileen Dean. The Adult's alcohol consumption was described as having become problematic, but in what way had not been detailed. The Adult had also faced a number of traumatic experiences in his childhood and into adulthood. It does not appear that the impact of these factors on the way that The Adult behaved, or felt threatened, were considered **(Recommendation 2)**.

6.5 No attempts were made to find out whether or not The Adult had come into contact with the criminal justice system for threatening or aggressive behaviour, and the police were not notified of the incidents on the general medical ward even though these featured the use of weapons; and no Safeguarding Concerns were reported to Lewisham Council despite other patients, with care and support needs, being victims or targets of some of the violent and aggressive incidents **(Recommendation 3).**

6.6 The Adult had been referred to the Lewisham Enhanced Recovery Community Team, which had declined him due to his chronic cognitive impairment, which was unlikely to improve and would be better managed by the Lewisham Mental Health Older Adult's Team. Mental Health Older Adult's Team, which supports people with dementia in the community, was unable to support The Adult since he did not have dementia. It is unclear what specialist community support services were therefore available for The Adult. Despite this he still moved to a non-specialist residential care service which supported people with dementia. The Adult was placed on Section 17 leave for two weeks, during which time support would be provided via SLaM, from Luther King Ward and The Adult could be recalled at any time **(Recommendation 4)**.

6.7 The SLaM risk assessment stated under *"Violence and Aggression",* that The Adult did not have a history of violence and aggression recorded on the electronic patient's records system. However, The Adult as noted above, had previously been aggressive at UHL and these incidents were referenced briefly within the records from the Psychiatric Liaison Team, although the full extent and severity of the incidents were not known to SLaM at the time of The Adult's admission to the Ladywell Unit, since these had not been collated, risk assessed and shared in a coherent way by LGT.

6.8 As part of its own review, SLaM identified that references to the incidents at UHL were recorded within the narrative in the *"Summary of Risk"* section of the risk assessment. Individual events and their severity are not clearly stated

within the relevant sections of the assessment, and much of the documentation had been copied and pasted from previous notes.

6.9 The Adult had made aggressive gestures with his walking stick whilst on SLaM wards but these were not recorded within the risk assessment, or in the risk events sections of the electronic patient records. The risk assessment therefore stated that there was no risk of violence and it would have required very detailed reading of very extensive daily records to identify the risks. This is unlikely to have been possible at the time. SLaM has identified the need for improvement in these areas, and this is also a matter for LGT to address **(Recommendation 3).**

6.10 Consequently, The Adult was placed in a non-specialist residential care service despite the risks to himself or others not being well understood.

6.11 Eileen Dean was placed at the care home since it met her needs. She had developed dementia and required more support than could be provided to her at home. The care home appears to have been suitable for Eileen but not for The Adult.

6.12 The Adult's placement at the care home was made outside of the usual hospital discharge pathway since The Adult was unable to return home. There was no expectation that The Adult's condition would improve and so a residential care home was sought for him. The Adult was granted Section 17 Mental Health Act leave for two weeks to the care home. Section 31.5 of the Code of Practice for the Mental Health Act notes that long term Section 17 leave for more than seven days may be granted to enable assessment of how a patient manages outside of hospital. Other options such as a home-based care package were not considered and a CTO was judged to be inappropriate to The Adult's needs.

6.13 The Adult was considered to have a form of dementia and was referred to residential services which support and care for people with dementia. The only service that agreed to take The Adult was the care home. The options available for The Adult were therefore limited **(Recommendation 5)**.

6.14 **Risk assessment and risk formulation was insufficient and information on risk was not well documented or communicated.**

6.15 The Adult was referred to the care home on 26 November 2020, 84 calendar days since his last recorded incident of violence and aggression. The referral contained reports of aggression, but these were considered to have been associated with The Adult's original hospital admission, and that consequently The Adult no longer posed risks to staff or other residents. It is true that just because someone has behaved violently does not mean that they will always behave violently, especially when the violent behaviour is associated with particular events or conditions. The Adult had Wernicke-Korsakoff's Syndrome, was disorientated and paranoid and had a UTI, all of which may have been associated with The Adult's aggressive and threatening behaviour. However, these do not correlate perfectly with the incidents and had not all improved before he moved to the care home. This suggests that despite the time that had

passed since The Adult's last recorded incident of violence and aggression, risks still remained.

6.16 For example, despite the assurance given to the social worker that The Adult's aggressive and threatening behaviour had been an isolated incident associated with his admission to the general hospital ward, the incidents involving The Adult were not isolated and began almost a month after he was admitted to hospital and his treatment for Wernicke-Korsakoff's Syndrome began. It would appear unlikely therefore that they were directly associated with the way The Adult had presented on 10 July, which had resulted in his hospital admission.

6.17 The Adult's Wernicke-Korsakoff's Syndrome was not cured with the use of vitamin B1 and he was considered not to have the potential for further rehabilitation, necessitating a residential care placement rather than a return home. The impact of Wernicke-Korsakoff's Syndrome on The Adult remained whilst he was at the care home.

6.18 The Adult was found to have a UTI, which can cause confusion and aggression, but this seems to have improved before he became violent and threatening.

6.19 The Adult's paranoia seems to have reduced as he had stopped making threats and believing that staff were trying to kill him, or to steal his possessions after being sectioned and after an increase in the dose of Quetiapine. Although, he remained fearful of the other patients on the mental health wards and made threatening gestures with his walking stick. This was understood to be the reasonable reactions of an older man with a form of dementia, living with younger people with mental health problems, who were unable to go on leave from the ward due to Covid-19 restrictions.

6.20 The Adult's aggressive gestures with his walking stick were not recorded as incidents or as risk events on electronic patient records. SLaM considered that there was a contextual factor in this, in that threatening with a walking stick was very low risk compared to other acts of aggression and violence on mental health wards. The Adult's aggressive gestures with his walking stick were assumed to be due to his poor memory and dementia-like condition, but they may also have been in response to transition and change in environment.

6.21 The Adult's Section 17 leave was for two weeks and SLaM identified that this was a protective and supportive factor since The Adult could be recalled to hospital.

6.22 SLaM's own investigation team found the use of *"copy and pasting"* in The Adult's records, which meant that information was not updated and a lack of detail on The Adult's use of a walking stick.

6.23 Consequently, the events and conditions that were believed to have caused The Adult to behave in a threatening and violent way, either do not directly correlate with these behaviours, or were still present when he was placed at the care home on Section 17 leave. There does not appear to have been further consideration of discharge to a High Security Psychiatric service and The

Adult's placement at the care home was made despite knowledge of his recent history of aggressive and threatening behaviour.

6.24 No formal risk assessment and formulation had been made to better understand, predict and intervene in The Adult's threatening and violent behaviour **(Recommendation 6)**.

6.25 **Covid-19 impacted on information sharing, quality assurance and risk awareness.**

6.26 Restrictions in response to Covid-19 impacted in numerous ways. The social worker made fewer visits to hospital wards, some meetings took place by video-conferencing, and quality monitoring by Contract and Quality Assurance officers were made virtually. There was evidence of innovation, for example, in using a video camera to conduct a tour of the care home during the quality monitoring visit, but this was hampered by poor wireless internet connectivity in some parts of the building.

6.27 The funding agreement for The Adult's placement at the care home was made by email without an Integrated Funding Panel meeting, but this was because The Adult's placement was due to have been made outside of the panel's meeting schedule, rather than due to Covid-19 restrictions. The Covid-19 restrictions at the time (for example HM Government (2020) COVID-19 Hospital Discharge Service Requirements) allowed discharge from hospitals to care homes.

6.28 Covid-19, however, did impact on The Adult and the sequence of services he received. The Adult's funding for the care home was approved on 30 November 2020, but he contracted Covid-19 on 2 December 2020 and transferred on 4 December 2020 to Florence Ward, the designated Covid-19 Ward at Lambeth Hospital. The Adult was to remain at Lambeth Hospital, on Luther King Ward from 17 December when he had recovered from Covid-19, until he moved to the care home on Section 17 leave on 22 December 2020.

6.29 Between 11 July 2020 and 22 December 2020, The Adult moved between four hospital wards and a care home, in three locations, and between two NHS Trusts, with associated disruption and a break in continuity. This posed a challenge in ensuring that information was transferred with him. During the process of this SAR, it was identified that information was not always easily accessible and transparent. Details of The Adult's episodes of threatening and aggressive behaviour were buried in narrative medical and nursing notes, which amounted to 1,724 pages **(Recommendation 11).**

6.30 On Luther King Ward, The Adult had become anxious, confused and tearful. He had also made aggressive gestures with his walking stick, which were not recorded as incidents or as risk events on electronic patient records. SLaM considered that there was a contextual factor in this, in that threatening with a walking stick was very low risk compared to other acts of aggression and violence on mental health wards. These were assumed to be due to The Adult's poor memory and dementia-like condition, but may also have been in response to moving and a change in environment and peer group. They may also have linked to The Adult's paranoia. To an extent in recognition of this, the

care home requested one-to-one day time support to assist The Adult to settle in. Night-time support was not requested because The Adult had been described as sleeping well at night, although whilst on the medical ward at UHL, The Adult had required one-to-one support during the day and night. At the care home, The Adult was also independently active in the early hours.

6.31 **Commissioning, Contracts and Quality Assurance**

6.32 The Adult's placement was made outside of the usual discharge pathway and was described as complex. This meant that The Adult was not going to return home but required a residential placement. There was a reference to this placement being secure in the UHL discharge letter to The Adult's GP, which referred to a *"High Security"* placement. It remains unclear how this request for a secure placement became minimised. The Adult moved from a general ward at UHL to a series of mental health wards, none of which met the criteria for *"High"* security and then to the care home which was not a secure placement. **(Recommendation 7)**.

6.33 The agreement to fund The Adult was made outside of the Integrated Funding Panel meeting schedule, but it appears that the usual documentation and scrutiny was used and this did not affect the decision to place The Adult at the care home. Had the panel met, however, there is the possibility that a discussion could have taken place over the most relevant service for The Adult, and that the need for a specialist service for people with alcohol-related conditions might have been identified if one was available. At no time during the out of panel decision making process, however, was one suggested. The Integrated Funding Panel members do not meet the people they make decisions about and instead rely on reports and a funding request.

6.34 At the time that The Adult was placed there on section 17 MHA leave, the care home had not notified the CQC that it had added the Service User Bands of younger adults (people below the age of 65 years old: The Adult was 62 years old) or people, like The Adult, with mental health needs, to its Statement of Purpose. The care home should have been aware of this as should the commissioners and those involved in making The Adult's placement.

6.35 It would appear that because the care home had a track record of supporting people with mental health needs since at least 2012, no checks had been made on whether the care home had added the appropriate Service User Bands to its Statement of Purpose. **(Recommendation 8)**.

6.36 The care home had been referred, and had accommodated and supported, twelve people with mental health needs during this time despite not having added this Service User Band to its Statement of Purpose until 2018, and not notified the CQC of this until 2021. This was not identified by the CQC during its inspection visits, or by Lewisham Council during quality and contract monitoring visits. Given that this has happened in one care home, it may have happened in others. **(Recommendation 9)**.

6.37 Care homes are responsible for ensuring that their Statement of Purpose includes the correct Service User Bands. They are not, however, restricted from accommodating and supporting other residents outside of these Service

User Bands unless the CQC has concerns that the care home is unsuitable for them. This means that the age groups and needs of residents can vary from those included in the Statement of Purpose. Despite this, commissioners and family members often use Service User Bands as an indication of the ability of a care home to meet their client's or their loved one's needs, and of whom else may be placed there with them.

6.38 This suggests that the Service User Bands in the Statement of Purpose and in the *"About the Service"* section in CQC inspection reports, cannot be relied upon as an indicator of who may be living there now, and of who may live there in the future. Lewisham Commissioners consider that they might be restricted by data protection regulations from accessing personal information about all residents in care homes. The CQC can access confidential information about residents in care homes, but does not hold data on them, and relies on care homes to ensure that they have the skills, competence, systems and processes to meet residents' needs. It is unclear who has oversight, above that of each care home, of the compatibility of residents. In the context of the killing of Eileen Dean by The Adult, and of the wider evidence of resident-on-resident abuse, the Lewisham Safeguarding Adults Board may wish to raise this matter at an appropriate regional or national level. **(Recommendation 10).**

6.39 According to staff who took part in this review, there was no pressure to place The Adult at the care home before Christmas. He was to be put on Section 17 MHA leave for two weeks.

6.40 The most recent contracts and quality monitoring visit, which took place before The Adult moved to the care home, and the CQC inspection which took place after The Adult had assaulted Eileen Dean, both identified the need for improvement in the quality, accuracy and consistency of records, including risk assessments, at the care home. There was also a need to match staffing levels to needs. The CQC found that the presence of two members of staff at night was insufficient to evacuate all the residents if there was a fire. It did not make any further statements about the adequacy of these staffing arrangements, although they had not prevented The Adult from entering Eileen's room and assaulting her. The CQC identified that because of these areas for development, the care home was not providing a service that was always safe. When The Adult was placed there, however, the CQC had rated the care home's safety as good. The CQC also identified that the care home's internal processes for quality assurance required improvement since they had not, amongst other things, identified inconsistencies and inaccuracies in record keeping.

6.41 It would appear, however, that in this case, the care home had enquired about the risks that The Adult posed and had received reassurance about them from a social worker, and then from medical staff. The care home considered that it had no basis on which to question the competence and knowledge base of these professionals. There is no evidence to suggest that the social worker and junior doctor gave false information to the care home. The social worker made it clear that they had been assured that The Adult's threatening and aggressive behaviour had been an isolated incident associated with his admission to hospital. The junior doctor appears to have been familiar with The Adult and said that he was not a risk. By this time, 84 days had passed since the last

recorded incident of violence and aggression, and there had been no recorded incidents on Powell Ward, but The Adult had made threatening gestures with his walking stick. Despite this, no risk assessment or formulation of the risks that The Adult posed had been made.

6.42 The care home did not provide specialist mental health services that could meet the needs of people with Wernicke-Korsakoff's Syndrome. Whilst it had supported people with mental health needs, which it had not included in its Statement of Purpose until 2018, nor notified the CQC until 2021, there was a need to check that it was able to meet The Adult's needs especially since there was no assessment or formulation of the risks that he might present **(Recommendation 11)**.

6.43 The accurate understanding and assessment of the risks that The Adult presented to others was the responsibility of all the organisations that The Adult was in contact with: LGT, SLaM, Lewisham Council and CCG, and the care home. Information, however, was either not gathered, not recorded correctly or assessed, and not passed on. Expecting one part of the system to increase its diligence in obtaining information about risk, for example, if other parts of the system have not gathered, recorded or received this information will not be effective **(Recommendation 12).**

6.44 The Adult was at least 20 years younger than most of the other residents at the care home. Despite reduced mobility, he was more able than the majority of the other residents and much less frail and vulnerable. He moved to a room on the second floor in an annex where two elderly women lived, as this was the only room that was available. It does not seem to have occurred to commissioners, or to the care home, that this placed vulnerable people at risk, despite the evidence of resident-on-resident violence in care homes and the impact of changing demographics reported by the ONS. Instead, and despite having been identified as requiring *"complex"* discharge and presenting with what was described as a rare condition, the commissioning response to The Adult was to provide a standard, rather than a specialist service to him **(Recommendation 13)**.

7 RECOMMENDATIONS

7.1 In the process of providing information for this SAR, participant organisations identified a number of single-agency actions. These are shown in Appendix 1 and are endorsed by this review, which recommends that progress on them should be reported to the Lewisham Safeguarding Adults Board.

7.2 The recommendations from this SAR will, therefore, focus on multi-agency and strategic actions and single agency actions not otherwise identified, and are as follows:

7.3 **Recommendation 1:** South London and Maudsley NHS Foundation Trust should introduce a clear clinical pathway for Wernicke-Korsakoff's Syndrome (or other forms of young-onset and acquired dementia). This could include accessing expertise in assessment, intervention and treatment and in identifying service options.

7.4 **Recommendation 2:** South London and Maudsley NHS Foundation Trust and Lewisham commissioners should include trauma and attachment informed analysis in individual risk and need assessments, and demonstrate how these link to and influence interventions, treatment and commissioning decisions for patients.

7.5 **Recommendation 3:** Lewisham and Greenwich NHS Trust and South London and Maudsley NHS Foundation Trust should always thoroughly risk assess incidents of threats and aggression on hospital premises where these involve weapons. This should be completed to determine if each incident should be reported to the police, or to the local authority as a Safeguarding Concern, if other patients are victims of this behaviour. The Lewisham Adult Safeguarding Pathway was introduced in April 2021 and provides further guidance on this subject. This should be followed by all professionals working in the borough.

7.6 **Recommendation 4:** South London and Maudsley NHS Foundation Trust and Lewisham commissioners should agree a protocol for which teams or services manage people with acquired brain injury/ dementia/ Wernicke-Korsakoff's Syndrome when they leave hospital to ensure that there is clinical supervision and oversight in the community.

7.7 **Recommendation 5:** South London and Maudsley NHS Foundation Trust and Lewisham commissioners should identify how many people they have treated and commissioned services for in the past five years who have acquired brain injury/ dementia/ Wernicke-Korsakoff's Syndrome, and what the outcomes were, and identify if specialist services should be commissioned (perhaps on a regional rather than local level). If such services exist already then South London and Maudsley NHS Foundation Trust and Lewisham commissioners should agree how they can be accessed. The further development of these services should be included in the local Dementia Strategy.

7.8 **Recommendation 6:** South London and Maudsley NHS Foundation Trust should introduce risk formulation using for example and amongst others: history; analysis of antecedents; behaviours and consequences and patients' own accounts of why they behaved in such a way; the impact of recent events and associated mental and medical conditions into risk assessments. The risk formulation should be used to establish levels of risk and risk mitigation plans.

7.9 **Recommendation 7:** If Lewisham commissioners disagree with the type of service that they have been requested to approve, then they should identify the reasons for this in writing, especially when decisions are made outside of panel meetings.

7.10 **Recommendation 8:** Lewisham commissioners should check the Statement of Purpose of services before making placements there to ensure that the correct Service User Bands are included.

7.11 **Recommendation 9**: Lewisham commissioners should check the registration status of all the care homes in Lewisham to ensure that their Statement of Purpose includes the Service User Bands of the clients who are placed there. This should then be carried out routinely at each inspection or monitoring visit.

7.12 **Recommendation 10:** The Lewisham Safeguarding Adults Board may wish to consider raising the status of Service User Bands, which are self-declared by providers and not always checked by the CQC, and highlight concerns about data protection being cited as a reason for commissioners and regulators not knowing the details of all residents in care homes, at an appropriate regional and/ or national level.

7.13 **Recommendation 11:** Commissioners need to assure themselves that providers can meet the needs of clients in situations where risks are unclear and not fully understood.

7.14 **Recommendation 12**: All of the agencies that came into contact with The Adult: LGT; SLaM; CCG; Lewisham Council and the care home, should review their information sharing processes and systems. They must ensure these are robust and that all relevant risk information is collected, assessed, collated and shared coherently with relevant partners; and effectively analysed, recorded, and used appropriately, when it is received.

7.15 **Recommendation 13:** Lewisham commissioners should consider the needs of all residents in shared accommodation services (i.e. those where residents do not live in self-contained accommodation) when making placements and identify how to move from accommodation-led, to needs-led commissioning.

APPENDICES

Appendix 1

Single Agency Recommendations

Name of Agency	Actions already agreed by individual agencies prior to SAR completion
The Joint Commissioning Team for Complex Care and Learning Disability at the London Borough of Lewisham	Ensure that pre-assessment training is delivered to all 24-hour providers, prioritising providers of older adults residential and nursing homes.
	The team will work with the CCG and London Borough of Lewisham safeguarding teams to RAG rate the quality of current assessments and put this rating and its reasons in writing to care home managers and, where appropriate, their head office.
	The team will undertake an annual review with local authorities who place individuals in care homes in the London Borough of Lewisham and seek their views as to the quality of placement and any concerns they may have. This will be incorporated into the next contract and quality assurance monitoring visit.
Lewisham Adult Integrated Commissioning Division (Mental Health Commissioning Team)	Ensure that all available client assessment information is provided to Lewisham Integrated Placement Panel members in advance of any 'out of panel' decision being made.
	The process for out of panel decisions should be incorporated in the terms of reference for the Integrated Placement Panel.
South London & Maudsley NHS Foundation Trust (SLaM)	Psychiatric Liaison services to complete full risk assessments for patients under their care to include all known risk events.
	All SLaM staff to ensure known risk events, even those outside of SLaM premises, i.e. as in the general hospital wards in this instance, are fully recorded as risk events and therefore are documented within the risk assessment to ensure full risk incidents are understood as part of the overall risk profile.
	When more than one community mental health team rejects a referral of a patient, this is escalated to the directorate service manager and senior directorate service manager to resolve the issue of which community mental health team will take responsibility for the patient's care.

Appendix 2

The Literature Reviewed

1) An internet search using Google to find open access journals and articles.
2) A search of the Royal Society of Medicine's on-line journals and related sources.
3) A search of the British Psychological Society's on-line journals and related sources.

Appendix 3

Alcohol-Use Findings from Safeguarding Adults Reviews

The Alcohol Change UK July 2019 report Learning from Tragedies: An analysis of alcohol-related Safeguarding Adults Reviews published in 2017, analysed 11 SARs and identified a number of themes common to all the reviews. Building on these, a further SAR (Andrew, Staffordshire and Stoke, 2022) identified eleven themes, which are:

- Non-engagement with services.
- Self-neglect.
- Exploitation of a vulnerable person.
- Domestic and child abuse.
- Chronic health problems.
- Mental health conditions.
- Traumatic events triggering alcohol intake.
- Lack of family involvement.
- High levels of alcohol intake and over-reliance on alcohol use to explain the adult's presentation.
- Regular contact with ambulance services and unpopularity with the local community or concerned neighbours.

The Alcohol Change UK July 2019 report also identified several practitioner perceptions that affected the way that services responded to these themes:

- Behaviours were seen as personal choice.
- The extent of alcohol consumption was underestimated.
- Lack of service capacity.
- Commissioning of services so that they are available and effective.
- High thresholds for support and for safeguarding concerns.
- Understanding of the Mental Capacity Act and legal literacy.

Appendix 4

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